Potential impact of the Human Rights Act on psychiatric practice: the best of British values?

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The Human Rights Act came into operation in October 2000, incorporating into English law the European Convention of Human Rights, which was originally formed to ensure no repetition of the atrocities of the second world war. The government intends to guarantee basic human rights in a broad range of circumstances, and this is relevant to the management of psychiatric patients.

The proposition of the act is that it will be unlawful for public authorities (including hospitals, social services, and prisons) to act in a manner incompatible with the convention. Lawyers have speculated at length as to possible challenges to the Mental Health Act, but clinicians seem less aware of the possible impact of this new legislation. The government has tried to reassure us. In March 2000 Jack Straw, the home secretary, told organisations "not to panic," saying the act is "an opportunity and not a threat" that safeguards "the best British values of fairness, respect for human dignity, and inclusiveness."[1]

Others express different views. Lord McCluskey, a senior judge in Scotland, where the convention was adopted after devolution, is reported as saying that the change has provided "a field day for crackpots, a pain in the neck for judges, and a goldmine for lawyers." In this article we use examples from Europe to review the potential impact on practice in England.

Summary points

- The Human Rights Act 1998 came into effect in October 2000 and incorporated articles of the European Convention of Human Rights into English law
- Potentially, this could allow psychiatric patients to challenge many aspects of their care
- However, European cases suggest that current clinical practice is largely compatible with the act
- Future legislation, policy, and procedure will be shaped by patients challenging existing practice using articles of the act, and a balance will have to be struck between the rights of individual patients and the rights of the community as a whole

Detention of people with mental disorder

Article 5 of the Human Rights Act involves the guarantee of liberty and is the most important in relation to the detention of mentally disordered people (see box 1). Previous interpretations of article 5 in the context of "persons of unsound mind" result from the decision of the European Court in the case of Winterwerp *v* the Netherlands.[2] The judge in this case indicated that, in order for the detention of a person of unsound mind to be lawful under article 5(1)e, the following minimum criteria must be satisfied:

- Except in emergency cases, no one can be deprived of liberty unless he or she can be reliably shown to be of unsound mind on the basis of objective medical expertise
- The mental disorder must be of a kind or degree warranting compulsory confinement
- The validity of continued confinement depends on the persistence of the disorder.

The court also held that the detention must be effected in accordance with a procedure prescribed by law.

The Mental Health Act allows detention on the basis of a mental disorder "of the nature or degree" that warrants compulsory admission to hospital. The case of R *v* Smith clarified that it was necessary only to show that the nature of the disorder was appropriate to allow continued detention,[3] thus allowing for patients

Box 1: Article 5 of the Human Rights Act

Article 5(1)—"Everyone has the right to liberty and security of person"

Parts (a) to (f) outline exceptions. Part (e) covers "the lawful detention of persons for the prevention of the spread of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants"

Article 5(2)—"Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him"

Article 5(4)—"Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful"

who relapse rapidly in the community to remain detained until they are more adequately treated. This interpretation might be challenged by the Human Rights Act, as the Winterwerp criteria state that continued detention in hospital depends on the persistence of the mental disorder—which may require the demonstration of symptoms of relapse.

In Stanley Johnson *v* United Kingdom, a patient detained under a restriction order at Rampton Hospital suffered a four year delay between his initial conditional discharge and his absolute discharge.[4] The delay was due to lack of appropriate hostel placement. This has implications for the provision of aftercare for detained mentally ill patients, as lengthy delays could allow challenges under the new Human Rights Act. The case of Aerts *v* Belgium also has implications for service provision.[5] In this case a mentally disordered patient was kept in prison because no hospital bed was available for him. He succeeded in pressing charges of false imprisonment. It seems likely that patients waiting for a bed in a unit of a different level of security could bring similar cases.

In Scotland in 1999 Noel Ruddle was released from psychiatric detention, having successfully argued that his condition was not treatable. Subsequent new legislation allowed continued detention on the basis of treatment being likely to prevent deterioration.[6] Three detained patients argued that this new act was in breach of article 5 of the convention.[7] In July 2000 three judges unanimously rejected this argument, holding that the convention should be approached on the basis that a balance be struck between an individual's rights and the community's interests. This allows for the detention of potentially dangerous untreatable patients within the scope of the Human Rights Act.

Informal patients

The Mental Health Act distinguishes between informal and detained patients. Detained patients are those detained under a section of the Mental Health Act, while informal patients are those who consent to admission and treatment. However, this distinction does not apply to two groups of patients—those coerced into admission informally and incapacitated patients unable to consent. The well known case of R *v* Bournewood concerned a man with profound learning disability who did not dissent from hospital admission but who did not have the capacity to consent.[8] His admission was under common law as the use of the Mental Health Act has been reserved for those incapacitated patients actively attempting to leave. The Mental Health Act Commission has described similar patients as "de facto detained."[9] These patients have none of the rights of detained patients to ensure that their detention is lawful.

In the above case the man's admission was found initially to be unlawful, overturning the fundamental assumption that patients could be admitted as informal patients in the absence of dissent. Subsequently, the House of Lords overruled this decision. The detention of these groups of informal patients probably contravenes the Winterwerp requirement that "detention must be in accordance with a procedure prescribed by law," which will lead to substantial changes in the management of these patients.

Box 2: Articles 2, 3, 6, and 8 of the Human Rights Act

Article 2—Everyone's right to life shall be protected by law

Article 3—No one shall be subject to torture or inhuman or degrading treatment or punishment

Article 6—Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law

Article 8—Everyone has the right to respect for his private and family life, his home, and his correspondence

Provision of information to detained patients

Article 5(2) of the Act concerns the information that should be given to detained patients, including details of their rights under the Mental Health Act and the new Human Rights Act. This information should include their reasons for detention and the methods by which their detention may be challenged. Nursing and medical staff probably urgently need further training about this in order to prevent challenges to detention under this article.

Confidentiality

Article 8 deals with the issue of confidentiality (see box 2), which up to this time has been a professional duty to the patient. From October, however, it has been a statutory obligation subject to article 8(2).

Nearest relative

Currently patients do not have the right to nominate their nearest relative. The Mental Health Act has a strict definition of a nearest relative under section 26.[10] The appointment of a nearest relative is meant to act as a safeguard, but it is not always beneficial for a patient. In JT *v* United Kingdom a patient detained under section 3 appealed against her inability to change her designated nearest relative, her mother.[11] Her stepfather had allegedly sexually abused her, and she objected to her mother receiving confidential information and discussing it with him. She alleged this violated her right to respect for her private life under article 8. The Human Rights Commission agreed that there had been a violation of article 8.

Article 8 will also lead to challenges of section 26 of the Mental Health Act. This specifies that a patient's "nearest relative" cannot be resident outside the United Kingdom, stating that any such person "shall be ascertained as if that person were dead." This could disallow the most appropriate person from being a patient's designated nearest relative.

Conjugal rights

Article 8 protects family and personal relationships. In particular, the issue of conjugal rights for detained inpatients may be brought to the courts, especially for those in longer stay units. This is likely to become an area of debate. It may require units to form specific

policies relating to their patients' rights to start or maintain a sexual relationship while resident in an inpatient facility.

Inhuman and degrading treatment

Article 3 (see box 2) has no exceptions. However, the terms "torture," "inhuman," and "degrading" are not defined in the article, and interpretation is therefore a matter of degree and individual judgment. In the case of A *v* the United Kingdom a patient detained at Broadmoor Hospital complained that his five weeks in seclusion amounted to inhuman and degrading treatment because of the length of seclusion and the insanitary conditions.[12] This was found not to be a breach of article 3, but a settlement enabled him to receive compensation, and new guidelines for the use of seclusion and for the seclusion environment came into place as a result.

This case nicely demonstrates the role of challenges under the Human Rights Act in shaping hospital policies, as well as potential future legislation. It is certainly possible that other aspects of treatment may be challenged as degrading. In the case of Grare *v* France a patient challenged the use of injectable old-style antipsychotic drugs, claiming he received inhuman and degrading side effects as a result of this treatment.[13] This was rejected as a breach of article 3, but the judgment noted that the "degree of seriousness" of side effects would have to be taken into account in further challenges to article 3, thus laying open an avenue for potential future challenges.

Suicide

Article 2 protects the right to life (see box 2). The recent case of Keenan *v* UK concerned Mark Keenan, a 28 year old man detained in Exeter prison.[14] He had a history of deliberate self harm but was found to be fit for adjudication and segregation after he assaulted two prison officers. Shortly after being placed in segregation, Mr Keenan hanged himself. His mother appealed under article 2, claiming that the state had failed to take appropriate steps to safeguard her son's life. She also appealed under article 3, stating that his treatment was inhuman and degrading.

The application was found admissible, but the ultimate decision was that there had been no breach of these articles. In summing up, however, the judges said: "Despite the relative dearth of Strasbourg applications to date concerning deaths in custody in the United Kingdom, there are likely to be a number of Human Rights Act challenges to such fatalities after the act comes into force." This is likely to extend to include the suicide of psychiatric inpatients, and potentially outpatients. This will have a substantial impact on hospitals' suicide prevention policies, as well as the resultant inquiries that now automatically follow suicides of psychiatric patients.

Mental health review tribunals

Two articles of the Human Rights Act are particularly relevant to the issue of tribunals. Article 5(4) entitles patients to a "speedy" review of detention and release if the detention is not lawful (see box 1). In E *v* Norway a patient applied to Oslo's city court for review of his psychiatric detention and received judgment eight weeks from the date of application.[15] The European Court held that this did not conform to the notion of "speedy" determination. Currently the target for a tribunal to review a detention under section 2 is within two weeks of a request for a review, but for a detention under section 3 it is within eight weeks of a request. The UK tribunal system frequently fails to achieve such rapid review of detention, and future challenge seems likely.

The provisions of article 6(3) include the right to ensure "equality of arms." In practice this means that a patient is entitled to exactly the same information as the tribunal panel. In addition, the patient would have the right to call witnesses and have them cross examined on his or her behalf. Future challenges may change the nature of mental health review tribunals in Britain and the workload of those professionals involved.

Conclusions

It seems likely that the Human Rights Act will result in a flood of legal cases concerning the management of people with mental disorder, particularly those detained under the Mental Health Act and those who are incapacitated. Just how this will affect the care of psychiatric patients, however, remains to be seen. In Scottish and other European cases challenges have largely been unsuccessful. It has been held that current clinical practice generally does not breach an individual's human rights. Indeed, recent Scottish case law has highlighted that an individual patient's rights may be of a lower priority than public safety.

Currently the Department of Health is asking for comments on these issues in the form of a European consultation document,[16] anticipating that legislation due in the next few years will need to be compatible with the Human Rights Act. This will include a new Mental Health Act and potential legislation for the detention of dangerous people with severe personality disorder, including, controversially, paedophiles. It is increasingly clear that a balance will need to be struck between the rights of individual patients and those of the community at large.

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15 E v Norway [1994] 17 EHRR 30.
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